STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS AMENDED SOD 03/09/11 A standard and abbreviated survey investigating KY#14981, KY#15553 and KY#14982 was conducted February 15-17, 2011. KY#14981 was substantiated and Immediate Jeopardy was determined to exist on 05/31/10 in 42 CFR 483.25 (F323 S/S "J") resulting in substandard quality of care, for failure to provide adequate supervision to prevent an elopement. Immediate Jeopardy was determined removed with all corrective action completed on June 7, 2010, prior to entrance of the state agency's investigation, making the deficient practice past noncompliance, Past Immediate Jeopardy. KY#15553 was investigated and substantiated with no regulatory violations identified and KY#14982 was unsubstantiated.	F 000	"The plan of correction is prepared and submitted as required by law. By submitting this plan of correction, Hopkins Care and Rehabilitation does not admit that the deficiency listed on this form exist, nor does the center admit to any statements, findings, facts, or conclusions that form the basis for the alleged deficiency. The center reserves the right to challenge in legal and/or regulatory or administrative proceedings the deficiency, statements, facts and conclusions that form the basis for the deficiency."	
F 253 SS=E	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This CONDITION is not met as evidenced by: Based on observation and interview, it was determined the facility failed to provide a safe and sanitary environment for residents. Sink faucets leaked and a commode tank constantly ran. A headboard was loose. Wheelchair handles were noted cracked and peeling. The findings include:	F 253	F 253 1. Room 14's sink and commode were repaired on 2-16-11 by the Maintenance Director. Room 27's faucet was repaired on 2-19-11 by the Maintenance Director. The men's bathroom #1 on the main hall sink was repaired on 2-16-11 by the Maintenance Director. The headboard for Room 12, bed A was repaired on 2-17-11 by the Maintenance Director. The wheelchair handles for the four	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Stephanie Organ — TITLE: Administrator — (X6) DATE: 3/14/11

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 1 During the initial Environmental tour of the facility, on 02/15/11 at 9:00am, the following items were noted in need of repair: Room 14 sink faucet leaked and the commode tank constantly ran water. Room 27 sink faucet leaked. The Men's bathroom #1 on the main hall sink faucet leaked. Room 12, bed A, headboard was loose on the bed. Four (4) unsampled residents had wheelchair handles that were cracked and peeling. Interview with Director of Maintenance on 02/17/11 at 9:50am revealed there was a maintenance log at each nurses station in which nurses listed maintenance issues that needed to be resolved. He stated he usually checked the logs multiple times a day, but at least every morning. Sometimes the staff just report to him instead of using the log. The Director of Maintenance stated he checks the wheelchairs monthly for needed repairs and the CNA's or therapy personnel also write in logs for needed repairs. He stated that the cracked and peeling arms on a wheelchair could cause skin tears on residents. When shown the cracked and peeling wheelchair arms, he stated he would look into getting them repaired. He further stated that the facility is old with galvanized pipes, and it is a struggle to keep the pipes from leaking, and he would work on the leaking faucets and leaking	F 253	(4) unsampled residents were repaired on 2-28-11 by the Maintenance Director. 2. The Maintenance Director has completed rounds on current resident's wheelchairs, faucets, sinks, commodes and headboards on 3-10-11 and items identified were repaired. 3, Re-education was provided to the Maintenance Director by the Administrator on 3-8-11 on preventative maintenance. 4. The Maintenance Director will complete monthly rounds for 3 months to identify needed repairs on wheelchairs, faucets, sinks, commodes and headboards. The findings will be reported by the Administrator to the Performance Improvement Committee for further recommendations. Compliance Date	3-14-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 253	Continued From page 2 commode.	F 253		
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on interview and record review it was determined the facility failed to provide the necessary care and services for one (1) resident of eighteen (18) sampled residents (Resident #8) to maintain the highest practicable physical well-being in accordance with the comprehensive care plan. The facility failed to follow physician orders to obtain a weekly skin assessment on Resident #8. The findings include: The facility failed to provide a policy on physician orders. Review of the physician's order dated 02/09/11 revealed a weekly skin assessment to be completed on Mondays. Review of the treatment record for Resident #8 revealed there was no weekly skin assessment documented. Review of the care plan for Resident #8 revealed	F 309	F 309 1. A skin assessment was completed on resident #8 on 2-21-11 by the licensed nurse. No skin impairment identified. The physician was notified on 3-11-11 by the Assistant Director of Nursing regarding the skin assessment. 2. The physician orders for weekly skin assessments were reviewed on current residents by the Assistant Director of Nursing on 3-8-11 and orders are being followed. 3. The nursing staff were re-educated on 3-3-11 by the Director of nursing for the completion of skin assessments as ordered by the physician. 4. Audits of physician orders and physician orders for weekly skin assessment to ensure they are completed will be performed by the Director of Nursing weekly for 4 weeks then monthly for 2 months. The findings will be	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 309	Continued From page 3 the intervention of documenting the skin assessment which would be recorded on the flow sheet; however, there was no flow sheet. Interview on 02/17/11, at 8:25am with LPN #4, revealed the order should have been in the treatment book. No sheet for the weekly assessment was present, and the assessment was due 02/14/11. It was further revealed that orders were to be checked by the following shift for completeness. Interview on 02/17/11 at 3:00pm with the Director of Nursing revealed the clinical management team reviews each order from the previous day and assures orders are carried out. It was further revealed that the medical record person compares the written order to what goes into the computer to produce the written orders for the staff to follow.	F 309	reported by the Director of Nursing to the Performance Improvement Committee for further recommendations. Date of Compliance	3-14-11
F 315 SS=E	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review it was determined the facility failed to	F 315	F 315 1. Residents #3 had catheter care and catheter tubing secured by the certified nursing assistant under guidance by the licensed nurse on 2-17 -11. Resident # 1 had catheter care and catheter tubing secured on 2-17-11 by the certified nursing assistant under guidance of the licensed nurse. The CNA care cards for residents #1 and #3 were revised to include catheter care on 2-16-11 by the licensed nurse.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 4 provide appropriate treatment and services to prevent urinary tract infections as evidenced by two (2) of eighteen (18) sampled residents (#3 and # 1) with indwelling catheters, and was not provided appropriate indwelling catheter care. The findings include: Review of the facility policy that the facility uses related to catheter care named Giving Catheter Care (NNAAP) Mosby, Inc., 2003 Chapter 20 of the Procedure Checklists revealed: 21: Secure the catheter. Coiled and secured tubing. 1. Resident #3 had been admitted on 04/27/09 with diagnoses of Pressure Ulcers, Chronic Pain, and History of Urinary Tract Infections. Review of the 11/24/10 Resident Assessment Protocol Summary (RAPS) revealed the resident triggered for Urinary Incontinence and did not get up to the bathroom every two hours, wore incontinent briefs, and would not cooperate with scheduled toileting. Review of the current physician orders revealed an indwelling catheter (16 French) to bedside drainage, however review of the CNA Care Cards (used by nursing assistants to deliver care) revealed Resident #3 was not receiving indwelling catheter care as ordered by the physician. In addition, review of the laboratory tests revealed a urinalysis had been completed on 02/01/11 and revealed a Urinary Tract Infection, at which time the physician had ordered Bactrim DS 800/160 daily for the infection. Interview with Resident #3 on initial tour on 02/15/11 at 7:30am revealed he/she felt that his/her brief was wet, however, interview revealed	F 315	2. Current residents with indwelling catheters were reviewed and CNA care cards were revised as indicated to include catheter care by the Assistant Director of Nursing on 3-10-11. 3. Nursing staff were re-educated on 3-3-11 by the Director of Nursing on completing catheter care and securing catheter tubing. 4. An observation of catheter care, securing of catheter tubing and audit of CNA care cards for catheter care will be completed weekly for 4 weeks then monthly for 2 months by the Director of Nursing /Assistant Director of Nursing. The findings will be reported by the Director of Nursing to the Performance Improvement Committee for further recommendations. Compliance Date	3-14-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 5 Resident #3 had an indwelling urinary catheter to bedside drainage. CNA #2 was asked to inspect Resident #3's brief for leakage of the indwelling catheter, and the resident was found to have a urine soaked brief. The indwelling catheter was still intact. Observation at 7:31am revealed CNA #2 changed the brief for Resident #3; however, CNA #2 failed to perform indwelling catheter care, and did not secure the catheter tubing, which left the catheter tubing hanging out around the adult brief. Indwelling catheter care was observed for Resident #3 on 02/17/11 at 10:20am. Observation of CNA #2 revealed failure to properly secure the catheter tubing to prevent pulling on the catheter. Interview with CNA #2 at that time revealed she was caught off guard on 02/15/11 at 7:30am when she checked the adult brief and that was the reason she did not perform catheter care at that time. CNA #2 also stated the indwelling catheter tubing is generally not secured, but positioned around the brief. 2. Resident #1 had been admitted on 02/13/07 with diagnoses of Cerebral Palsy with Hemiplegia, Neurogenic Bladder, Diabetes Melitus, Depression, and Seizure Disorder. Review of the 10/06/10 annual Resident Assessment Protocol Summary (RAPS) revealed the resident triggered for Indwelling Catheter. Review of the current physician orders revealed an indwelling catheter (26 French with a 30cc balloon) to bedside drainage, however review of	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 315	Continued From page 6 the CNA Care Cards (used by nursing assistants to deliver care) revealed Resident #1 listed as continent of bladder and incontient of bowel, appliances for Resident #1 use was listed as pad/briefs and an indwelling. In addition, review of the laboratory tests revealed a urine culture had been completed 01/16/11 and revealed Proteus Mirabalis Infection. A second urine culture was completed on 02/04/11 and revealed Enterobacter Aerogenes Infection. And a third urine culture on 02/11/11 revealed E. Coli Infection Urinary Tract Infection, at which time the physician had ordered Augumentin 875 mg twice a day for seven (7) days for the infection. Indwelling catheter care was observed for Resident #1 on 02/16/11 at 10:40am. Observation of CNA #2, providing care for Resident #1, revealed the same wash cloth was being used to wash the peri-area, and the CNA repeated several wipes with same wash cloth. The catheter tubing was not properly secured to prevent pulling on the catheter. CNA #2 stated the indwelling catheter tubing is generally not secured, but positioned around the brief. Interview with the Assessment Coordinator on 02/15/11 at 10:00am revealed Resident #3 had the indwelling catheter inserted about four months ago due to the resident's incontinence and need for assistance with healing a Stage III pressure sore. Interview with LPN #1, on 02/16/11 at 10:40am, revealed Resident #1 had an indwelling catheter for his/her neurogenic bladder. LPN #1 reported it was the responsibility of the nurses to supervise the CNA, and to ensure the care was provided in relation to the facility policies.	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323 SS=J	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide adequate supervision to prevent accidents for one resident (#6) of eighteen sampled residents. The facility failed to follow the Elopement Policy. The facility failed to assess the resident for elopement risk and/or the need for increased supervision when the resident was found attempting to exit the building. These failures resulted in Resident #6, who had verbalized the intent to leave the facility twice on 05/31/10, exiting the facility on 05/31/10 without staff knowledge. The facility's failure to provide adequate supervision placed residents at risk for serious injury, harm, impairment or death. Immediate Jeopardy and Substantard Quality of Care was determined to exist on 05/31/10. The findings include: Review of the facility elopement policy, dated January 2008, revealed an elopement occurs when a resident leaves the center or "safe area" without authorization or appropriate supervision.	F 323	Past noncompliance: no plan of correction required.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 8 All residents are assessed upon admission for "exit seeking/wandering" behaviors. The resident is evaluated regarding cognition, locomotion, mood/behaviors, past history, and ambulation status. If the resident is determined to be at risk for elopement, the resident's picture is placed in an "elopement binder" and a specific care plan is developed. Under the portion of the policy titled The Elopement Risk Program (Section 3), the nursing assistants are to notify the nurse when new wandering/exit seeking behaviors are observed. The nurse will then validate the behaviors through observations, interviews, and assessment. Closed record review of Resident #6's medical record revealed the resident was admitted to the facility on 04/30/10 with diagnoses which included Dementia, Atrial Fibrillation, frequent falls with traumatic brain injury (2009), and left temporal lobe skull fracture from a fall at home. The initial MDS (minimum data set) assessment completed on 05/07/10 revealed the facility assessed the resident as requiring extensive assistance from staff for transfers, ambulation, and locomotion, and as having short term memory recall deficit with impaired decision making skills. Review of the MDS assessment and the comprehensive plan of care revealed the facility had not identified Resident #6 at risk for elopement and had not developed a care plan related to elopement. Review of the nurses' notes, dated 05/14/10 at 4:30pm, revealed the resident refused medications, became combative with staff by hitting and yelling, and refused all treatments. The physician was notified and the facility transferred Resident #6 to an outpatient psychiatric center. The resident was returned to the facility, on	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 9 05/15/10 at 12:25am, with no new orders received. The resident was confused and was repeatedly asking to go to his/her home. Record review revealed on 05/25/10 a contract Psychiatric service came to the nursing facility and conducted an initial evaluation. During that psychiatric evaluation, the resident stated to the interviewer his/her chief compliant was "I am trying to get out of here as soon as possible." The evaluation findings were Alzheimer's Disease with disturbance of mood and behaviors with anxiety noted. Medication was ordered which included Seroquel (antipsychotic medication) to be given at noon and bedtime, and Ativan (for agitation/anxiety) 0.5mg IM every six hours as needed. Later on 05/25/10, the nurses' note revealed the resident was wandering in and out other residents' rooms yelling and swinging at staff who came near. Review of nurses' note dated 05/27/10 revealed the medication orders from the Psychiatric services were reviewed. The nurses' note dated 05/28/10, written by the Director of Nursing (DON), revealed the medication changes and Psychiatric evaluation were discussed in the CARES committee meeting. Interview with the Director of Nursing, on 02/16/11 at 9:30am, revealed she could not recall if the Psychiatric evaluation findings were discussed in the 05/28/10 CARES meeting, "but if it was documented, then we must have". The DON stated she was responsible for reviewing the Psychiatric evaluation findings and the staff nurse was responsible for taking any medication orders. Record review revealed the facility addressed the medication changes; however, there was no	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 10 documented evidence the facility address the resident's statements of wanting to "get out of the facility as soon as possible." Review a facility investigative report, dated 05/31/10 and written statements from staff working that date, revealed Resident #6 was observed sitting at the office exit door at 11:30am by two staff members. When the staff tried to redirect Resident #6, the resident asked for the code to the "box" because he/she "was leaving". The two staff members did not report their findings to the nurse. Between 12:00 noon and 12:15pm, the resident attempted to get into the kitchen and had to be redirected. After lunch, at approximately 1:20pm, the resident attempted to follow a family member out the back door and stated, "I am leaving, "I have to go." Per the facility's investigative report, this was not reported to the nurse and the resident's supervision was not increased. At approximately 1:40pm, the alarm to the office exit door was activated. Nurse (LPN#2) responded and silenced the alarm. Interview with LPN#2, on 02/16/11 at 9:00am, revealed when the alarm was activated she went to the office exit door, stepped outside the door and looked around, but did not go into the parking lot. She did not see any residents, so she silenced the alarm and went back to the front of the building. She stated she did not validate all residents were present at that time. Review of the former employee CNA #5's written statement, dated 05/31/10 at 4:00pm, revealed on 05/31/10 she had found Resident #6 in the side parking lot unsupervised. The statement revealed the resident was found in a wheelchair at the end of the parking lot, attempting to get the wheelchair up on a sidewalk approximately five feet from a	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 11	F 323		

busy highway. Further interview with LPN #2, review of nurses' notes, dated 05/31/10 at 1:55pm, and the facility's investigative report, confirmed that at 1:55pm, CNA #5 brought the resident to the nurses' station and told her she had found the resident outside in the parking lot. LPN #2 stated she was unaware the resident had left the building. Per LPN #2 interview and record review revealed a head-toe assessment was completed which identified that Resident #6 had not sustained any injuries. LPN #2 notified the Administrator, DON, Resident #6's physician, and family of the elopement. Upon the arrival of the DON, approximately thirty minutes later, an investigation of the elopement was initiated and validation of all residents were completed.

Observation during the survey, February 15-17, 2011 revealed the heavily traveled highway in front of the nursing facility was approximately five to six feet from where the resident was found. Additionally, a train track was observed approximately 500 feet away from the front of the facility with trains passing over those tracks several times a day.

Review of the facility investigation, dated June 1, 2010 and interview with the Administrator and Director of Nursing, on 02/15/11 at 3:45pm, revealed Resident #6 had left the building through the office door on 05/31/10 at approximately 1:40pm. The Administrator stated to reach the office area you must first go through the residents' dining room. The interior door between the dining room and the offices was left opened at the time of the elopement because that was where staff clocked in to work. The Administrator stated she thought Resident #6 had pushed on the exit door until it released and then exited the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 12 building through the door. Per the investigative report, the door alarms were checked by the Maintenance Director on 05/31/10 and all were found to be working properly. The door to the dining room was closed with an alarm placed on the door on 05/31/10. Vanguard Door Company representative was contacted and came to the facility to check the alarm doors on 06/01/10. He verified the alarm doors were working properly. Continued review of the investigative report and interview with the DON on 02/16/11 at 9:30am revealed when the staff, working the day of the elopement was interviewed, she found a knowledge deficit regarding the elopement policy. The investigation found three different staff members either heard Resident #6 verbalize the intent to leave and actually attempted to leave with a family member prior to the elopement. The DON indicated the staffs' failure to report their findings to the nurse and LPN#2's failure to search the parking lot placed Resident #6 at risk for harm. The DON stated she recognized this knowledge deficit and began immediate "on the spot" training on 05/31/10 with all staff who were working the day of the elopement. The facility implemented mandatory staff training on 05/31/10 and did not allow any staff to work until trained. Training through group meetings with staff (nursing, housekeeping, and dietary) was conducted on 06/01/10 and those employees not present at those training sessions, were mailed the information and responded with a certified letter acknowledging they received the information and read the material. The educational material for the training included: Elopement Policy/Procedures, Abuse/neglect	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 13 policy, Identifying and Reporting residents at risk for elopement, and elopement drills. Record review revealed the facility reassessed residents at risk for elopement and care plans were updated as needed. Interview with the Administrator on 02/17/11 at 11:05am, revealed she conducted monthly elopement drills to ensure ongoing staff knowledge and education. She stated QA (quality assurance) meeting was held on 06/01/10 with the Medical Director's input. QA meetings were held monthly that include the Medical Director, Administrator, DON, and department heads to identify and assess corrective action for prevention of accidents/elopements. Closed record review revealed the facility assessed Residents #6 for elopement risk on 05/31/10, developed a care plan, and placed a picture of the resident in the elopement binder. The facility completed a comprehensive care plan which detailed diversional activities were to be offered when the resident exhibited exit seeking behaviors. The resident was discharged from the facility on 08/31/10. Record review validated that the facility reassessed residents at risk for elopement and care plans were updated as needed. Review of the expanded sampled residents (who were identified to be at risk for elopement) revealed Residents #13, 14, 15, 16, 17, and #18 had elopement assessments, care plans, and each resident's picture had been placed in the elopement binder by 06/01/10. Observation, on 02/17/11 at 10:25am, revealed the facility maintained an elopement binder at each nurses station. Review of the elopement	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14 binders validated the elopement binders were current. On 02/16/11 at 1:00pm, the office exit door was observed having a code alarm which required a code to be entered in order for the alarm door to release. Review of the training records on 02/24/11 validated training of all staff was completed on 06/07/10. The educational material for the training included: Elopement Policy/Procedures, Abuse/neglect policy, Identifying and Reporting residents at risk for elopement, and elopement drills. Interview with LPN #2, on 02/16/11 at 9:00am, revealed the training received after the elopement included the elopement policy and procedures. She stated she would go out into the parking lot and look around whenever an exit alarm was activated. In addition, she would immediately validate all residents were present in the building. Interview with a Dietary Aide, on 02/16/11 at 10:15am, revealed she had attended training on 06/01/10 regarding the facility's elopement policy. She stated she would tell a nurse if she saw a resident attempt to leave the facility. Interview with CNA #3 and #4, on 02/17/11 at 10:05am, validated knowledge of which residents were elopement risk and why. The CNAs had knowledge of what actions to take if a resident verbalized they were leaving or exhibited new wandering behaviors. They stated they would report the information to the nurse. Interview with a housekeeper, on 02/17/11 at 10:25am, revealed she knew which residents were at risk for elopement and where the elopement binder was located. She stated training was provided to all staff regarding elopement. Review of the facility log for the alarm doors	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15 revealed the doors had been checked daily during the month of May 2010 and continued through the survey, February 15-17, 2011. Observation of the alarm doors with the facility Maintenance Director, on 02/16/11 at 1:00pm, validated all alarming exit doors were working properly. Observation revealed staff response to the alarm activation was 20-30 seconds. Observation of the door between the dining room and office area was kept closed with a code alarm placed on the door. Record review of monthly elopement drills validated the facility completed these monthly drills to ensure ongoing staff knowledge and education. Record review further validated that the facility's QA (quality assurance) meeting was held on 06/01/10 and monthly thereafter with the Medical Director's input. These meetings were validated through signature sheets that include the Medical Director, Administrator, DON, and department heads to identify and assess corrective action for prevention of accidents/elopements. The Immediate Jeopardy was determined to be removed and all corrective action was completed on 06/07/10, prior to the State Agency's initiation of the investigation on 02/15/11.	F 323		
F 425 SS=E	483.60(a),(b) PHARMACEUTICAL SVC - ACCURATE PROCEDURES, RPH The facility must provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement described in §483.75(h) of this part. The facility may permit unlicensed personnel to administer drugs if State law permits, but only under the general supervision of a licensed nurse.	F 425	F 425 1. The Emergency Drug Kit was replaced by pharmacy on 2-17-11. 2. An Emergency Drug Kit System was implemented on 2-17-11 by the Director of Nursing.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 16 A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident. The facility must employ or obtain the services of a licensed pharmacist who provides consultation on all aspects of the provision of pharmacy services in the facility. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to provide pharmaceutical services to ensure a procedure was in place to acquire replacement medications for the Emergency Drug Kit (EDK). The facility did not timely replace the EDK after medications were removed to make emergent/urgent medications readily available to the residents. The findings include: The policy provided by the facility on Emergency Medication Supply (Oct. 2005) revealed medication used from the EDK are to be replaced per existing policy and procedures, however, the facility had no policy. Observation on 02/15/11 at 2:00pm of the EDK stored at the nurse's station revealed the EDK had previously been opened and medication removed without replacement. Further	F 425	Current residents were reviewed by the Director of Nursing on 2-17-11 for medication availability and no issues were identified. 3. Re-education with licensed nursing staff was completed on 3-3-11 by the Director of Nursing concerning the process related to the Emergency Drug Kit. 4. The replacement log and the Emergency Drug Kit will be checked daily by the Director of Nursing or member of the nurse management team for 3 months. The findings will be reported to the Performance Improvement Committee for further recommendations. Compliance Date	3-14-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 17 observation revealed papers titled Emergency Box Usage Sheets filled out with the name of the medication given, its dosage and the resident receiving the medication. The sheets were placed in the bottom of the EDK. The dates on the sheets revealed medications had been used on 02/10/11, 02/11/11, 02/12/11 and 02/15/11 without pharmacy notification for replacement. Review of the emergency box usage sheets revealed the medication Phenergan 25mg. had been given on 02/10/11 and again on 02/11/11, leaving no Phenergan 25mg. in the EDK. It was further revealed the following drugs had been removed from the EDK and not replaced: Rocephin 1gm. vial, Augmentin 875mg tablet, Ceftin 250mg tablet, Flagyl 250mg tablet and Bactrim DS tablets. These medications were no longer available for residents needs. Interview on 02/17/11 at 1:25pm with LPN #1 revealed when pharmacy replaces (swaps out) the EDK, the usage sheets are collected from the bottom of the box. Interview on 02/17/11 at 1:35pm with LPN #2 revealed the process for EDK replacement involves removing the bar code sticker from the top of the closed EDK, scanning it and faxing it to the pharmacy for a replacement EDK. The pharmacy will then deliver a complete EDK. It was also revealed the facility may call the pharmacy and request an exchange of the EDK. Interview on 02/17/11 at 1:45pm with the Administrator revealed it is expected for the pharmacy to have a 24 hour turn around time to get medications back to the facility.	F 425		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 425	Continued From page 18 Telephone interview with the Pharmacy Representative on 02/17/11at 3:00pm revealed they delivered a replacement EDK on 02/10/11 and another had not been requested as of 02/17/11 at 2:00pm. The Pharmacy Representative revealed the process involves the facility notifying the pharmacy to request a replacement EDK and it would be delivered. The Pharmacy Representative reported the facility must notify the pharmacy or they would not deliver the EDK without a phone or fax request.	F 425		
F 431 SS=D	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the	F 431	F 431 1. The vials of flu vaccine and tuberculin serum were disposed of on 2-15-11 by the licensed nurse. No resident was affected. 2. Other vials of medication were reviewed for date opened documentation and for disposal of expired medications by the Assistant Director of Nursing on 2-15-11. 3. Licensed nurse and medication technicians were re-educated on 3-3-11 by the Director of Nursing on dating open vials and disposing of expired medications. 4. Vials of medications and biologicals will be reviewed for dates when opened as appropriate	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 19 Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to label, date and store all drugs and biological used in the facility in accordance with currently accepted professional principles. One (1) flu vaccine vial and one (1) tuberculin serum vial had been open and available for use; however, the medications were not dated to indicate the date the vials were open. The findings include: Review of the facility provided policy on House Supply Medication dated 2005, revealed that medications must bear the expiration date. Observation on 02/15/11 at 2:00pm revealed one (1) vial of flu vaccine and one (1) vial of tuberculin vaccine stored in the refrigerator at the front hall nursing station had been open and available for use. Further observation revealed the vials failed to indicate the date opened. Interview on 02/17/11 at 1:25pm with the Director of Nursing revealed it was the responsibility of clinical management and medication technicians to date opened medications and dispose of	F 431	and expiration dates. Undated or expired medications will be discarded by the nurse and re-ordered as indicated. Each unit will be checked weekly by the Director of Nursing or Assistant Director for 3 months and findings reported to the Performance Improvement Committee for further recommendations. Completion Date	3-14-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 20 expired medications. It was further revealed that everything was to be dated, as is their rule and policy.	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of	F 441	F 441 1. Resident # 1 had proper catheter care and catheter tubing secured on 2-17-11 by the certified nursing assistant under the guidance of the licensed nurse. CNA #2 was re-educated by the Director of Nursing on 2-26-11 regarding hand hygiene between serving meal trays and catheter care. LPN #1 was re-educated by the Director of Nursing on 3-3-11 on cleaning scissors prior to use on treatment products. 2. The Director of Nursing/Assistant Director of Nursing will perform observation of infection control procedures during catheter care, meal tray pass and wound care treatment completion by 3/14/11. Any residents affected will have corrective action implemented at the time of the observation.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 21 infection. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review the facility failed to ensure the infection control procedures were maintained to prevent the spread and cross contamination during the meal service, wound care and indwelling catheter care. The findings include: Review of the facility's policy 02/16/11 relating to Fundamental of Standard Precautions Hand Hygiene, Lippincott 8th Edition, Chapter General Procedures and Treatment Modalities, Page 1033 revealed 1. Hand hygiene is the single-most important measure to reduce the risks of transmitting microorganisms. 2. Cleaning hands with soap and water or an alcohol-based waterless hand rubs as promptly and thoroughly as possible between patient cntacts and contaminated equipment or articles is vital for infection control. It may be necessary to clean hands between task on the same patient to prevent cross-contamination of different body sites. Observation of noon meal services on 02/16/11 revealed Certified Nurse Assistant (CNA) #2 served nine (9) unsampled residents meal trays without any hand hygiene completed between serving each meal tray. Indwelling catheter care observed for Resident	F 441	3. The nursing staff was re-educated on catheter care, hand hygiene between serving meal trays, cleaning equipment and process of wound care treatment by the Director of Nursing on 3-3-11. Observations of catheter care, hand hygiene between serving meal trays, cleaning equipment and treatment completion will be completed by the Director of Nursing and Assistant Director of Nursing weekly for a minimum of 4 weeks. 4. The Director of Nursing or the Assistant Director of Nursing will observe wound care treatments, hand hygiene during pass of meal trays, cleaning equipment and catheter care once each week for 4 weeks, then monthly times 2 months. The results will be presented by the Director of Nursing to the Performance Improvement Committee for further recommendations. Compliance Date	3-14-11

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 22 #1, on 02/16/11 at 10:40am, provided by CNA #2. Observation of CNA #2 revealed the same wash cloth was being used to wash the peri-area, and several wipes with same wash cloth was observed. Review of the current physician orders revealed an indwelling catheter (26 French with a 30cc balloon) to bedside drainage; however, review of the CNA Care Cards (used by nursing assistants to deliver care) revealed Resident #1 was listed as continent of bladder and incontient of bowel. Appliances for Resident #1's use were listed as pad/briefs and an indwelling. In addition, review of the laboratory tests revealed a urine culture had been completed 01/16/11 and revealed a Proteus Mirabalis Infection. A second urine culture was completed on 02/04/11 and revealed Enterobacter Aerogenes Infection. And a third urine culture was completed on 02/11/11 and revealed E. Coli Infection Urinary Tract Infection, at which time the physician had ordered Augumentin 875 mg twice a day for seven (7) days for the infection. Observation of the wound care provided by Licensed Practical Nurse (LPN) #1 on 02/16/11 at 10:40am revealed the scissors used during the dressing change was carried in LPN #1's pocket prior to the dressing change and was utilitized to cut the wound packing and gauze without cleaning prior to use. Interview with LPN #1 on 02/16/11 at 10:40am revealed Resident #1 has a indwelling catheter for his/her neurogenic bladder. LPN #1 reported it ws the responsibility of the nurses to supervise the CNA and to ensure the care was provided in relation to the facility policies. He/She reported	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING _____ B. WING _____	02/17/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 23 the scissors should have been cleaned before use; not carried in the pocket and then used for wound care.	F 441		
F 502 SS=D	483.75(j)(1) PROVIDE/OBTAIN LABORATORY SVC-QUALITY/TIMELY The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. This REQUIREMENT is not met as evidenced by: Based on observation, interview and record review, it was determined the facility failed to assure laboratory services were accurate and timely as evidenced by four (4) culture swabs with an expiration date of 12/2010. The findings include: The facility failed to provide a policy on expired supplies. Observation on 02/15/11 at 2pm in the medical supply storage room revealed four (4) expired culture swabs. The expiration date noted was 12/2010. Interview on 02/17/11at 3pm with the Director of Nursing revealed the Assistant Director of Nursing goes through the supplies and checks expiration dates. It was further revealed, all items in storage are available for use.	F 502	F 502 1. The four (4) expired culture swabs were disposed of on 2-15-11 by the Assistant Director of Nursing. 2. Current inventory was checked for expiration dates on 2-21-11 by the Director of Nursing and the Assistant Director of Nursing. No residents were impacted. 3. Staff re-education was conducted on 3-3-11 by the Director of Nursing to check expiration dates before using any product and dispose of any expired product. An inventory log to include expiration dates will be maintained by the Director of Nursing or Assistant Director of Nursing. 4. An audit of product inventory will be completed weekly for four weeks then monthly for two months by the Director of Nursing or Assistant Director of Nursing for any supplies that have expiration dates. Any identified expired products will be disposed of. The Director of Nursing will report findings to the Performance Improvement Committee for further recommendations. Compliance Date	3-14-11.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	185167	A. BUILDING 01 - MAIN BUILDING 01 B. WING _____	02/15/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HOPKINS CARE AND REHABILITATION CENTER	460 SOUTH COLLEGE STREET WOODBURN, KY 42170

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K 000	INITIAL COMMENTS A Life Safety Code survey was initiated and conducted on 02/15/11 to determine the facility's compliance with Title 42, Code of Federal Regulations, 483.70 (Life Safety from Fire) and found the facility to be in compliance with NFPA 101 Life Safety Code 2000 Edition. No deficiencies were identified during this survey.	K 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.